STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004975	A. BUILDING: _____ B. WING _____	R-C 06/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT CATHERINE REGIONAL HOSPITAL	2200 MARKET ST CHARLESTOWN, IN 47111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S 000}	INITIAL COMMENTS This visit was for a followup to the State hospital complaint survey that was conducted on 04-14-14. Dates: 06-03 & 04-14 Facility Number: 004975 Surveyor: John Lee, RN Nurse Surveyor Supervisor Three previously cited deficiencies were found corrected. Saint Catherine Regional Hospital is in compliance with 410 IAC 15-1.4-1, 15-1.5-2 and 15-1.5-6, Hospital Licensure Rules. QA: claughlin 06/13/14	{S 000}		